LOCAL HEALTH LINK

Cabinet for Health and Family Services | Department for Public Health

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COMMISSIONER'S COMMENTS

Kentucky Drug Summit

As many of you know, Governor Fletcher asked Lt. Governor Pence to chair a Kentucky Drug Summit to look into ways to do a better job of dealing with the state's substance abuse problems. The Lt. Governor appointed some 51 members to sit on one of three task forces: one for law enforcement, one for treatment, and one for prevention and education. I have had the opportunity to be part of this endeavor nearly from the start as leader of the treatment task force. The summit has met in sixteen different communities: Covington, Maysville, Ashland, Prestonsburg, Paducah, Hopkinsville, Owensboro, Henderson, Bardstown, Louisville, Lexington, Danville, Hazard, Pikeville, Somerset, and Bowling Green. Many members of the Public Health Community attended these meetings and heard first-hand what people had to say. For those who did not have a chance to attend any of the meetings, here are a few of my observations as a participant in the treatment discussions.

Substance Abuse Treatment:
These observations and descriptions are based on comments made by dozens of Kentuckians at meetings of the Kentucky Drug Abuse Summit across the state. Some of the "keeper comments" include:

- "Children have a right to be children,"
- "The current system robs people of the hope of recovery. Don't rob us of that hope; instead, give us hope by giving us the freedom to seek recovery (recovering person),"
- "Don't sweep this under the rug,"
- "Don't stigmatize me…don't stigmatize us,"
- "With treatment, I learned how to love me for the first time in my life,"
- "We cannot incarcerate ourselves out of this situation,"
- "A lot of good work has already been done so let's not reinvent the wheel—let's cooperate and share,"
- "This is a chronic life-long condition with relapses and it requires long term management,"
- "Never stop going to meetings so you don't give yourself permission to start abusing again (recovering person),"
- "Stay sober and carry the message,"
- "One size treatment does not fit all,"
- "Men and women require different treatment,"
- "Alcoholics and users can spot at risk kids in a heartbeat,"
- "These huge consolidated high schools are a fertile environment,"
- "It is easier for kids to get drugs than cigarettes these days,"
- "Some of us just aren't going to get the message without significant consequences (recovered addict),"

Substance abuse in Kentucky has become a significant public health problem because the prevalence is increasing, it is widespread across Kentucky, and it impacts men, women, children and families without regard to age, race, socio-economic group, religion, or income. It is destroying significant elements of the economy, it is destroying the future for many children and young adults, and, it meets the definition of a public health problem. "A health problem becomes a public health responsibility if or when it is of such a character or extent as to be amenable to solution only through systematized social action. Its relative importance varies with the hazard to the population exposed. This hazard may be qualitative, in terms of disability or death; quantitative in terms of population affected; it may be actual or potential."

Today over 40,000 of Kentucky's 4 million citizens are in prison or on parole, mostly due to drug related offenses. The result is that over 1% of the population is unlikely to get a good job and return to a productive life. We know who is it risk of becoming an addict. *Anyone with a family history of alcohol or substance abuse is at higher risk than normal of becoming an addict.* The risk is also

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much higher among children whose parents are incarcerated, children who do poorly in school, children with low self-esteem, children living in broken homes, and increasingly, children who are obese or have other physical problems.

We know that good treatment works. There are examples all across the state and the country. Forty years ago, a 5% success rate was a good in alcoholism treatment programs. Today 70% success rates are common and among physicians it is closer to 95%. Those counties that have drug courts swear by them. Communities that have programs to strengthen child self-esteem have demonstrated significant declines in school disciplinary problems.

Good treatment requires a variety of combinations…and it has to be readily available without long waiting times and without requiring travel over long distances. In the ideal setting, the practitioner, friend, or other person who is able to get the patient to acknowledge their dependency needs to be able to make an immediate referral for assessment and entry into the system. The combination can be as extensive as detoxification treatment, assessment, referral to inpatient treatment followed by up to a year in a residential treatment site, intense ambulatory treatment, and finally life long counseling. At the other end of the continuum is much less costly intense ambulatory care treatment followed by life-long counseling. Experience has shown that women and men both do better more quickly when their care is in gender specific groups instead of mixed gender groups.

There are many barriers to ensuring good treatment for all who need it. One significant problem is a lack of resources. The task force heard about problems with inadequate insurance coverage, excessive staff turnover due to low salaries, long waiting times, inadequate numbers of inpatient facilities, and problems with actually getting transportation to the treatment facility. But there are other significant barriers…many of them societal like discrimination, stigmatization, lack of jobs, and a serious lack of knowledge about drug abuse by providers, schools, parents, and the public in general. Finally, there are organizational issues like missing critical services or counter productive turf battles among provider groups and specialists.

The subsequent reports will describe the ways persons go from at risk to addicted, detected, referred, treated/incarcerated, and managed over the long term. Additional information will describe the requirements for good treatment; identify the barriers preventing this treatment, and make general recommendations regarding actions that would improve the situation. There are no hard and fast recommendations on how to prioritize responses but in general, activity that would ensure the availability of statewide intensive ambulatory treatment facilities would be a good start.

Submitted by: Rice C. Leach, M.D., Commissioner
Department for Public Health

ACH

SOUTHEAST KENTUCKY INTIATIVE FOR PEDIATRIC ASTHMA (SKIPA)

The Southeast Kentucky Initiative for Pediatric Asthma (SKIPA) is a collaborative program utilizing community resources to promote asthma awareness and asthma management. SKIPA, serving Perry, Harlan, Owsley, and Knott Counties, is funded through a three-year Rural Health Outreach Grant to the Kentucky River District Health Department awarded in 2001. Collaborating partners include: Cumberland Valley District Health Department, Appalachian Regional Hospital (ARH), Area Health Education Center for ARH, University of Kentucky Center for Rural Health, Asthma and Allergy Center in Hazard, and the Department for Health Services. SKIPA staff consist of: Maxine Ritchie, RN BSN, Program Coordinator/Perry County Community Encourager; Lonnie Saylor, Community Encourager Harlan County; Anne Rowland RN, Community Encourager Knott and Owsley Counties; and Tammy Ritchie, Lay-Health Outreach Worker for Perry, Knott, and Owsley Counties.

The Goals of the Program are: (1) to increase asthma awareness by providing information to parents, schools, doctors, organizations and other interested people; (2) to educate families of children who have been diagnosed with asthma and those at risk; (3) to reduce emergency room visits, hospitalizations, and schools absence of children with asthma, and; (4) decrease asthma attacks and their severity in the four counties.

A variety of activities have increased asthma awareness and education. SKIPA staff have made home-visits to parents and caregivers of asthmatic children, have provided trainings to a variety of interested organizations and individuals, and made asthma presentations throughout the four county regions. They have participated in regional health fairs, community wide parenting events, patient education at the Health Department sites, and provided asthma support in the schools for parents and students. In addition, they have surveyed physicians that treat pediatric patients about their modes of treating asthma in their practice, providing education in pediatric clinics in Harlan, Perry, and Owsley Counties. SKIPA has also developed Local Asthma Task Force Boards (LAT) in each county. These LAT Board assist the program with individual needs to be addressed in each county.

The Program has better educated the communities of the four counties to help promote a more safe, healthy, and active life for children with asthma. For more information about the program please contact Maxine Ritchie at (606) 436- 2196.

Submitted by: Patricia McLendon

LABORATORY

UNDERSTANDING HEPATITIA B TESTS

The 3 part Hepatitis B Blood panel includes the following:

1. Hepatitis B Surface Antigen (HBsAg): The surface antigen is detectable during disease process. It becomes detectable about 1 month after exposure, peaks at 2 to 3 months, and levels off 6 months after exposure.
2. Hepatitis B Surface Antibody (anti-HBs): The surface antibody is formed in response to the hepatitis B virus. Your body makes this antibody if you have been vaccinated, or if you have recovered from a hepatitis B infection. Someone who is surface antibody positive is not infected, and cannot pass the virus on to others.
3. Hepatitis B Core Antibody (anti-HBc): A positive test indicated that a person might have been exposed to the hepatitis B virus. This antibody does not provide any protection or immunity against the hepatitis B virus.

Testing Criteria

Appropriate testing criteria for HbsAg

1. Prenatal Screening
2. Prenatal with known exposure by positive sex partner
3. Infant of HBsAg positive mother
4. Perinatal Screening

Appropriate testing criteria for Hepatitis B Surface Antibody (anti-HBs)

1. Prenatal with known exposure by HBsAg positive sex partner
2. Infant of HBsAg positive mother at 12-15 months of age (after therapy)
3. Local health department employee for post vaccine
4. Local health department employee following needlestick exposure

Appropriate testing criteria for Hepatitis B Core Antibody (anti-HBc)

1. Prenatal with known exposure to HBsAg positive sex partner
2. Household members and/or sexual contacts of HBsAg positive prenatal
3. Local health department employee following needlestick exposure

*Special request can be made for others by calling Epidemiology 502-564-4478.

Interpretation of the Hepatitis B Panel

Test	Results	Interpretation
HBsAg	negative	susceptible
anti-HBc	negative	
anti-HBs	negative	
HBsAg	negative	immune due to vaccination
anti-HBc	negative	
anti-HBs	positive	
HBsAg	negative	immune due to natural infection
anti-HBc	positive	
anti-HBs	positive	
HBsAg	positive	acutely infected
anti-HBc	positive	
IgM anti-HBc	positive	
anti-HBs	negative	
HBsAg	positive	chronically infected
anti-HBc	positive	
IgM anti-HBc	negative	
anti-HBs	negative	
HBsAg	negative	may be recovering from acute HBV infection
anti-HBc	positive	may be distantly immune with very low levels of anti-HBs
anti-HBs	negative	may be chronically infected, undetectable level of HBsAg

Submitted by: Brenda Shipp, Serology Supervisor

LABORATORY WORKERS MAKING A DIFFERENCE

The Division of Laboratory Services(DLS) in Frankfort will be celebrating National Medical Laboratory Week the week of April 19-23. This year's theme is Making a Difference Every Day.

The staff of microbiologists, chemists, laboratory technicians, laboratory assistants, aides, clerical, and administrative staff will take time during the week to form good working partnerships with each other. A current staff of 50 performs laboratory testing for various Department for Public Health programs. Testing includes newborn screening, pesticide, rabies, influenzae, chlamydia, gonorrhoea, milk, water, HIV, enteric pathogens, bioterrorism agents, and tuberculosis. DLS works closely with various programs in the department.

DLS is moving forward in areas of new technology such as PCR and amplified molecular testing to provide the best service to the people of Kentucky. Our current DLS staff will continue to provide laboratory expertise and excellence in the future just as they have done in the past.

LAB WEEK CULTURE DAY

Left to Right: Leighann Bates, Robin Cotton, and Peggy Clatos

Submitted by: Meloney Russell

LocalOPs

Issue: The Department for Public Health (DPH) was asked to consider assisting LHD influenza vaccine procurement by ordering (and distributing) vaccine.

DPH Response:

- Given recent history, it is anticipated and appreciated that there may well be concerns related to influenza vaccine supply and/or timeliness of supply.
- Under Kentucky State Government Purchasing policies and procedures, DPH cannot preorder vaccine at guaranteed (perhaps higher price) to secure delivery.
- LHDs have access to state/federal contract pricing for **all** vaccines, including influenza vaccine, once contracts are in place (usually mid May). For details as to how to order, contact Paul Bentley at (502) 564-4510.
- DPH currently has no vaccine depot or system for distribution of vaccine other than the established out of state commercial entity. The current system is tied to a vaccine ordering and management system that is linked to the Centers for Disease Control (CDC) and Prevention's National Immunization Program. Ordering additional vaccine through this mechanism may well reduce or imperil Vaccines for Children dosage allocations.

Kentucky Health Department Association (KHDA) Response:

- KHDA remains concerned regarding the timeliness and availability of flu vaccine.
- KHDA acknowledges the inability for DPH to preorder vaccine.

Resolution:

KHDA will continue to preorder flu vaccine through the leadership of a Local Health Department Director to assure timely supply/delivery--even if price was potentially higher.

DPH will not order and distribute non-Vaccines for Children (VFC) flu vaccine unless approved from CDC that ordering additional vaccine will not imperil VFC dosage allocations.

The mechanism is in place for each LHD to order **all** vaccines through the established state price contract as deemed necessary.

Submitted by:
Betty H. Olinger, Ed.D., Division Director

STATE/LOCAL SPOTLIGHT

BEAUTIFUL
LAKE CUMBERLAND DISTRICT – MCCREARY COUNTY HEALTH DEPARTMENT

Whitley City – The McCreary County Health Department has several changes.

A year ago, the facility launched its redesigned clinic aimed at providing efficient, modern patient care.

Patients will still be able to enjoy all the services the health department offers as scheduled, including: Vital statistics, environmental programs, school health, infant/preschool well-child programs, immunizations, WIC, HANDS program, resource library, adult prevent care, cancer screening, prenatal/postpartum care clinic, diabetes education and counseling, family planning, health education for teens, tobacco control programs, genetic counseling, grief counseling, and hypertension education/management.

What's different is that staffers have divided into teams and developed procedures (fewer overlapping appointments, walkie-talkie communication, etc.) which should eliminate most of the stops patients used to make, which in turn eliminates most of the time patients spend waiting.

According to Debbie King, the facility tracked several patients and discovered that, for example, the average prenatal visit lasted 73 minutes while family planning patients could expect to spend 145 minutes at the health department.

"We know our patients have a lot of things to do," King said. "We want to work toward an efficient, modern clinic with patient care in mind."

Patients can now expect to be greeted at the front door and follow-up calls if an appointment is missed. The health department has been working with private consultant Dr. George Kent to develop the radical redesign. While the program is being launched here, it may soon become the region's standard.

"It's such a major change that we wanted to try it out before changing other departments," Lake Cumberland District Health Director Shawn Crabtree said. "McCreary County was chosen for the pilot program because it is a medium-sized clinic and the staff has good morale. They know teamwork and were anxious to take on something challenging."

While the program is on a 90-day trial, Crabtree said it shows a great deal of promise.

"It was not uncommon for patients to be here two hours," Crabtree noted. "We've run test clinics with this model and the average is down to 45 minutes. Patient and staff satisfaction look good. It's efficient which is economically good."

In fact, a comment board in the lobby stands as a testament to patients' satisfaction with the "fast, friendly" new way of doing things. King added that another plus is that staff members rotate

roles, so someone can always fill in if a staff member is absent.

In order to better accommodate all patients, the health department encourages patients to keep appointments as scheduled for faster and more efficient service. Call 376-2412 for more information.

Submitted by: Shawn Crabtree,
Lake Cumberland District Health Director
Written by: Janie Slaven, Record Staff Writer

EDITOR'S NOTE:

Please submit articles, state/local staff spotlight nominees, or suggestions for the Local Health Link to:

Betty H. Olinger, Ed.D., Director
LHDO
275 East Main Street, HS1W-E
Frankfort, KY 40621
E-mail: bettyh.olinger@ky.gov
502-564-4990 or (FAX) 502-564-2556

Format Editor: Debbie Bohannon